

# ATTACHMENT 7

## Sample CMS 1500 claim form for nurse midwife services (Antepartum care in a Health Professional Shortage Area)

| HEALTH INSURANCE CLAIM FORM  |    |    |    |                    |  |  |       |                  |              |   |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>   |    |    |    |                    |  |  |       |                  |              | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)<br><b>1234567890</b>  |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)<br><b>Recipient, Im A.</b>   |    |    |    |                    |  |  |       |                  |              | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)   |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 5. PATIENT'S ADDRESS (No., Street)<br><b>609 Willow St</b>   |    |    |    |                    |  |  |       |                  |              | 7. INSURED'S ADDRESS (No., Street)  |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| CITY<br><b>Anytown</b>   |    |    |    |                    | STATE<br><b>WI</b>   |  |       |                  |              | CITY<br>  |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ZIP CODE<br><b>55555</b>   |    |    |    |                    | TELEPHONE (Include Area Code)<br><b>(xxx) xxx-xxxx</b>                   |  |       |                  |              | ZIP CODE<br>  |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)<br><b>OI-P</b>   |    |    |    |                    |  |  |       |                  |              | 11. INSURED'S POLICY GROUP OR FECA NUMBER   |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER  |    |    |    |                    |  |  |       |                  |              | a. INSURED'S DATE OF BIRTH<br>MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>  |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| b. OTHER INSURED'S DATE OF BIRTH<br>MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>   |    |    |    |                    |  |  |       |                  |              | b. EMPLOYER'S NAME OR SCHOOL NAME   |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| c. EMPLOYER'S NAME OR SCHOOL NAME  |    |    |    |                    |  |  |       |                  |              | c. INSURANCE PLAN NAME OR PROGRAM NAME  |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| d. INSURANCE PLAN NAME OR PROGRAM NAME   |    |    |    |                    |  |  |       |                  |              | d. IS THERE ANOTHER HEALTH BENEFIT PLAN?<br><input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>                        |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.   |    |    |    |                    |  |  |       |                  |              |   |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.<br>SIGNED _____ DATE _____  |    |    |    |                    |  |  |       |                  |              | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.<br>SIGNED _____ |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. DATE OF CURRENT: MM DD YY  |    |    |    |                    | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY |  |       |                  |              | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION<br>FROM MM DD YY TO MM DD YY   |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE  |    |    |    |                    |  |  |       |                  |              | 17a. I.D. NUMBER OF REFERRING PHYSICIAN   |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19. RESERVED FOR LOCAL USE   |    |    |    |                    |  |  |       |                  |              | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES  |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)<br>1. <b>643.10</b>  |    |    |    |                    |  |  |       |                  |              | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.  |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23. PRIOR AUTHORIZATION NUMBER   |    |    |    |                    |  |  |       |                  |              |   |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th colspan="4">A DATE(S) OF SERVICE To</th> <th>B Place of Service</th> <th>C Type of Service</th> <th colspan="2">D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</th> <th>E DIAGNOSIS CODE</th> <th colspan="2">F \$ CHARGES</th> <th>G DAYS OR UNITS</th> <th>H EPSDT Family Plan</th> <th>I EMG</th> <th>J COB</th> <th>K RESERVED FOR LOCAL USE</th> </tr> </thead> <tbody> <tr> <td>12</td><td>10</td><td>03</td><td></td><td>11</td><td></td><td>99204</td><td>TH QB</td><td>1</td><td>XX</td><td>XX</td><td>1.0</td><td></td><td></td><td></td><td></td> </tr> <tr> <td>12</td><td>15</td><td>03</td><td>22</td><td>11</td><td></td><td>99213</td><td>TH QB</td><td>1</td><td>XXX</td><td>XX</td><td>2.0</td><td></td><td></td><td></td><td></td> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> |    |    |    |                    |  |  |       |                  |              |   |                 |                                      |       |                                     | A DATE(S) OF SERVICE To  |                                     |  |  | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER |  | E DIAGNOSIS CODE | F \$ CHARGES |  | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE | 12 | 10 | 03 |  | 11 |  | 99204 | TH QB | 1 | XX | XX | 1.0 |  |  |  |  | 12 | 15 | 03 | 22 | 11 |  | 99213 | TH QB | 1 | XXX | XX | 2.0 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A DATE(S) OF SERVICE To  |    |    |    | B Place of Service | C Type of Service  | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER |       | E DIAGNOSIS CODE | F \$ CHARGES |   | G DAYS OR UNITS | H EPSDT Family Plan                  | I EMG | J COB                               | K RESERVED FOR LOCAL USE |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 12   | 10 | 03 |    | 11                 |  | 99204  | TH QB | 1                | XX           | XX  | 1.0             |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 12   | 15 | 03 | 22 | 11                 |  | 99213  | TH QB | 1                | XXX          | XX  | 2.0             |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |    |    |    |                    |  |  |       |                  |              |   |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |    |    |    |                    |  |  |       |                  |              |   |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |    |    |    |                    |  |  |       |                  |              |   |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |    |    |    |                    |  |  |       |                  |              |   |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |    |    |    |                    |  |  |       |                  |              |   |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN  |    |    |    |                    | 26. PATIENT'S ACCOUNT NO.<br><b>1234JED</b>                              |  |       |                  |              | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |                 | 28. TOTAL CHARGE<br>\$ <b>XXX XX</b> |       | 29. AMOUNT PAID<br>\$ <b>XXX XX</b> |                          | 30. BALANCE DUE<br>\$ <b>XXX XX</b> |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)<br><b>J.M. Williams</b> MM/DD/YY  |    |    |    |                    |  |  |       |                  |              | 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)  |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| SIGNED _____ DATE _____  |    |    |    |                    |  |  |       |                  |              | 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #<br><b>I.M. Nurse Midwife</b><br><b>1 W. Williams</b><br><b>Anytown, WI 55555 87654321</b>               |                 |                                      |       |                                     |                          |                                     |  |  |                    |                   |  |  |                  |              |  |                 |                     |       |       |                          |    |    |    |  |    |  |       |       |   |    |    |     |  |  |  |  |    |    |    |    |    |  |       |       |   |     |    |     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)